Government of Western Australia
North Metropolitan Health Service
Mental Health
Youth Mental Health

Working therapeutically with gender diverse young people

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YouthLink

Contact

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YouthLink

Delivering a Healthy WA

Objectives

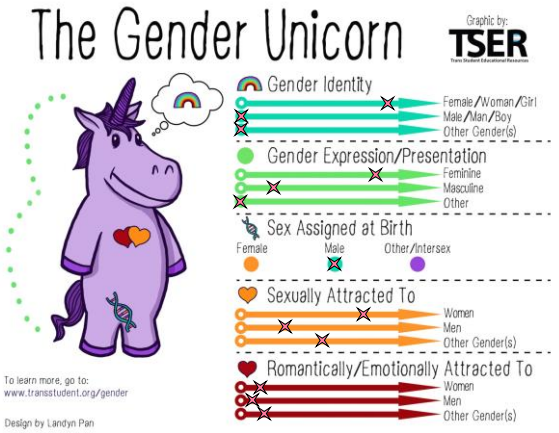
- Assessment and best practice treatment models for gender diverse young people
- Therapeutic/clinical issues that often arise when providing intervention
- Discussion about how to improve inclusive and knowledgeable practice within schools

Delivering a Healthy WA

Refresher

- Sex vs. sexuality vs. gender
- Identity vs. expression
- Gender terminology – transgender, trans, non-binary, gender queer, transman, transwoman, MTF/FTM, sistergirl, brotherboy
- Sexuality terminology – gay, lesbian, pansexual, asexual

Delivering a Healthy WA



Understanding Mental Health

Trans Pathways

Trans Pathways

the mental health experiences and care pathways of trans young people

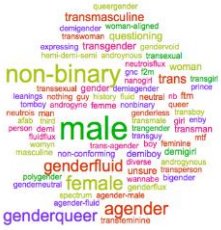
Penelope Strauss
Angus Cook
Sam Winter
Vanessa Watson
Dani Wright Toussaint
Ashleigh Lin

Participants

- **859 trans and gender diverse young people**
  - 639 assigned female at birth
  - 220 assigned male at birth
  - Mean age 19.37 (SD=3.15)
- **194 parents and guardians of trans young people**
  - 89.7% mothers
  - 6.7% fathers
  - 5.1% other parent/guardians

Gender & Sexuality of participants

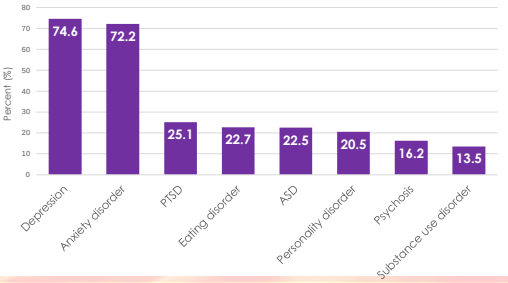
Gender identities: 29.7% male, 15.0% female, **48.5%** non-binary



Gender identities

Sexual orientations

Mental health

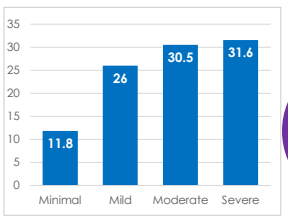


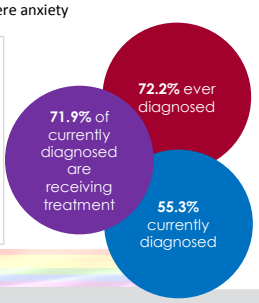
Lifetime prevalence of self-reported psychiatric diagnoses received, N=756

Anxiety

Generalised Anxiety Disorder 7-item Scale (GAD-7)

- 62.1% with levels of moderate or severe anxiety



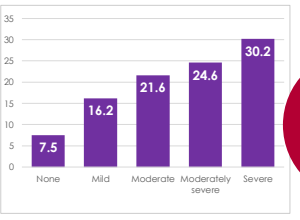


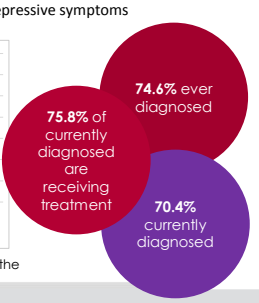
Severity of anxiety symptoms during the previous two weeks (%), N=845

Depression

Patient Health Questionnaire for Adolescents (PHQ-A)

- 76.4% with moderate to severe depressive symptoms





Prevalence of depressive symptoms during the previous two weeks (%), N=736

Putting it into perspective

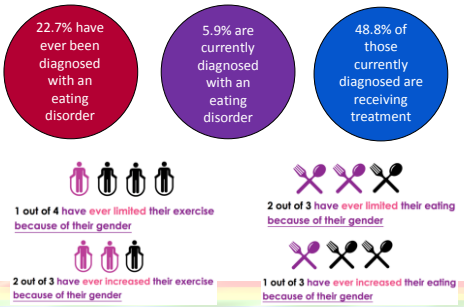
Depressive disorders

- Trans young people are experiencing severe depressive disorders at almost **7 times** the rate of the general Australian young population (compared to 11-17 year olds)

Anxiety disorders

- In the general Australian population (aged 16-85), 14.4% had an anxiety disorder within the last 12 months, compared to 62.1% of trans young people with current levels of moderate or severe anxiety
  - → **4.3 times** the rate of the general population

Eating disorders



I severely restricted my diet (maybe 300 – 700 calories) from the ages of 13-14 when my hips/thighs began to develop. I stopped eating because I was terrified and thought they looked out of proportion to my body, because they made me look feminine [Male, 17)

Exercising in a binder can be extremely uncomfortable and dangerous, esp for people with difficulties breathing already. Besides that, exercising in public (at gyms, for example) can be very upsetting as non-passing trans folk often have to pick between changerooms, specifically gendered rooms/equipment etc [Male, 19]

I do have an eating disorder and have been losing quite a lot of weight particularly since I've moved out of home. This is because of my discomfort with my body but also due to my low self-esteem. I like to exercise to maintain health and also to try to change my body but I don't like doing it because I fear testosterone build-up. [Female, 21]

Autism spectrum

Autism Quotient (AQ-10)

- Clinically seeing a high rate of autism and gender dysphoria
- Case reports and small studies that hint of a possible association warranted inclusion of the AQ-10

Our results:

- **35.2%** warrant further diagnostic tests
- **22.5%** of participants reported a diagnosis of ASD

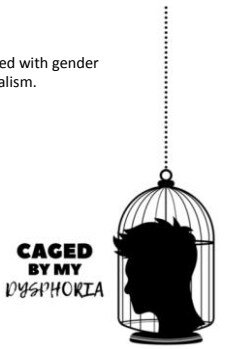
- This is compared to 1-2% of the Australian population having an ASD diagnosis
- Controversial because some people are using this to justify not providing hormone therapies
- Further investigation needed in this area

Gender dysphoria

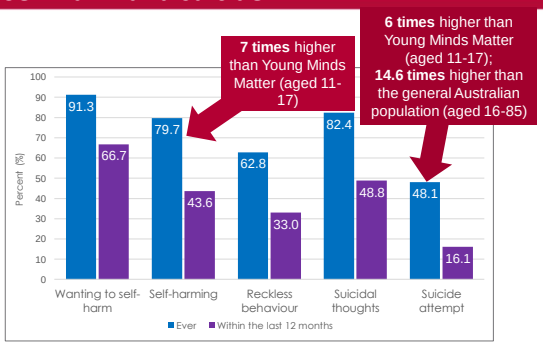
We asked participants if they have been diagnosed with gender dysphoria, gender identity disorder or transsexualism.

Psychiatric diagnosis often required to receive gender-affirming hormones.

- **47.9%** have been diagnosed by a health professional
- 38.2% have not received a diagnosis
- 13.8% were not sure if they have received a diagnosis



Self-harm and suicide



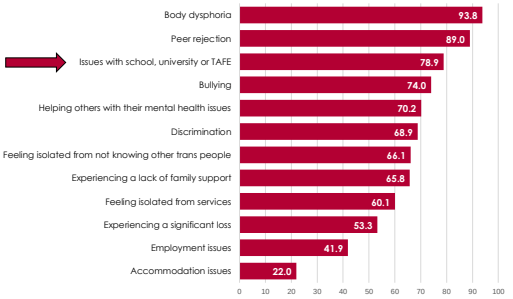
Self-reported self-harming and suicidal behaviours (N=739)

Note: there were no significant differences between participants aged <18 and ≥18.

Self-harm and suicide

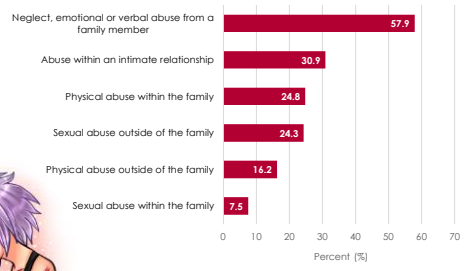
- Factors most closely associated with suicide attempts and self-harm were:
  - Accommodation issues, including homelessness
  - Physical abuse within the family
  - Sexual abuse outside of the family
  - School, TAFE, or university issues
  - Bullying
  - Being abused by an intimate partner

Drivers of poor mental health



Lifetime exposure of potential drivers of poor mental health (N=691)

Experiences of abuse



Lifetime exposure of abuse (N=670)

Accommodation issues

- **22%** have experienced accommodation issues (including unstable accommodation, homelessness and couch-surfing)
- Suicide attempt: **OR=5.308** (3.298, 8.545; *p*<0.001*)

- **17.8% have been homeless**
- 38.9% have accessed crisis accommodation
- 43.2% felt their gender identity **was not respected** by the crisis accommodation service they sought

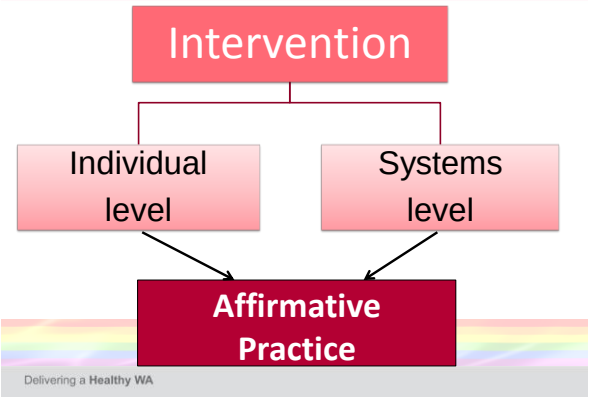
> Well it is hard to get housing in Australia unless you have a job and getting a job while transitioning in Australia is hardly possible so then a lot of trans people who **don't have the support [of] their family and friends** or don't live with family end up in crisis accommodation. [Female, 25]

Minority Stress

- DSG is not the precipitator of stress; it's the social context!
- DSG are exposed to additional stressors cisgender and heterosexual people don't experience
- Experience and expectations of discrimination, rejection, victimisation, prejudice etc;
- Internalised heterosexism, homophobia and transphobia
- Concealment of self

The Fallout

- Increased isolation
- Increased risk of experiencing violence
- Early drop out of education
- Higher rates of homelessness
- Reduced help seeking behaviours
- Increased use of drugs and alcohol
- Poorer health outcomes
- Increased rates of suicide



Individual Level

My psychologist was lovely but I felt like I had to explain a lot of things to her eg. What queer means. She was super accepting but I felt like she had no knowledge of gender diversity so it was just skimmed over [Agender, 25]

Assessment

Diagnosis

- The controversies, pros and cons of diagnosis
- Con: pathologisation of identity
  - "Homosexuality", "egodystonic sexuality"
  - "Transexualism", "Gender identity disorder"
- Pros:
  - Capturing the source of distress
  - Current model requires diagnosis to qualify for gender affirming / gender reassignment hormonal and surgical treatment (if desired)
  - Being visible in data

Gender Dysphoria

- Previously referred to as Gender Identity Disorder (GID) in DSM-III and IV
- DSM-V: Gender Dysphoria
- The distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender
- Not all individuals will experience distress as a result of such incongruence – many will be distressed if the desired physical interventions are not available
- The current term is more descriptive than the DSM-IV and focuses on ***dysphoria*** as the clinical problem and not ***identity*** per se

Body Dysphoria

- Intense hatred of own body as it does not reflect their gender, can lead to:
  - Self-harm
  - Eating disorders
  - Self-neglect
  - Distress regarding menstrual cycle
  - Social anxiety

DSM-V Diagnosis

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, **of at least 6 months duration**, as manifested by two or more of the following indicators:
- 1. a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
- 2. a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- 3. a strong desire for the primary and/or secondary sex characteristics of the other gender
- 4. a strong desire to be of the other gender **(or some alternative gender different from one's assigned gender)**
- 5. a strong desire to be treated as the other gender **(or some alternative gender different from one's assigned gender)**
- 6. a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

Unlikely to spontaneously volunteer sexuality or gender issues

You need to ask, invite, discuss and welcome

(Less than 40% disclose their identity!)

Ask the questions

Experience with MH Services

- 66% had seen a mental health professional in the past 12 months
- At least half had a negative experience with a health professional
- 30% avoided seeing a mental health professional due to a previous negative experience

Being asked signals safety and inclusivity!

Common areas to assess further with gender diverse clients

- Childhood – clothing preference, play, names, future self
- Expression of gender– now and past
- How they manage body dysphoria, if present eg. Eating issues, binding, self-harm, preoccupation with appearance
- Body – now and past
  - Feelings/thoughts about their body – specific to secondary sex characteristics (bottom vs. top dysphoria), menstruation
  - Seeing self in mirror – showering
  - Puberty
  - Sexual fantasies/desires – what body have, avoidance

Common areas to assess further with gender diverse clients

- Transitioning
  - Where are they at in the process of socially transitioning? Any anxieties?
  - Have they commenced medical transition? Do they want to medically transition? Barriers to accessing?
- Hypervigilance
- Using public bathrooms
- Specific safety concerns, especially during transition
- Fantasies of self vs. actual (identity exploration)
- Common comorbid issues

Ask the questions

- "Who are you attracted to? Girls, guys, both, or neither?"
- "Many people can find that they struggle with or have some mixed feelings about their gender/who they are attracted to, is this an issue/concern/question for you?"
- "How would you describe your sexuality? Have you always felt this way?"
- "Was the sex assigned to you when you were born the gender you feel most comfortable with?"
- "How do you identify in your gender?"
- Use Continuum – "imagine yourself on this scale between male and female, where would you sit at present (if at all)? Has it always been this way for you?" (can also use for sexual orientation)

Ask the questions

- "How would you describe your experience of gender?"
- "Do you think that the gender you were assigned restricts the way you live, behave, or express yourself?" (e.g., dress, appearance etc).
- "How much do you feel you can be yourself at home?"
- "Do you feel forced to behave in certain ways because of your gender/sexual orientation? What happens when you don't act in those ways? How do you feel in yourself?"
- "My understanding of genderqueer is……, how does that fit with how you identify as genderqueer?"

Ask the questions

- If you don't ask, you may not be told
- Become accustomed to asking
- Asking normalises, provides opportunity for young person to explore, and shows that you are okay in talking about these topics
- Don't make assumptions eg. Based on their current relationship or gender expression
- Examine your fear that it may "offend"
- Be genuine, kind, and empathetic
- If you make a mistake, it's the repair that counts

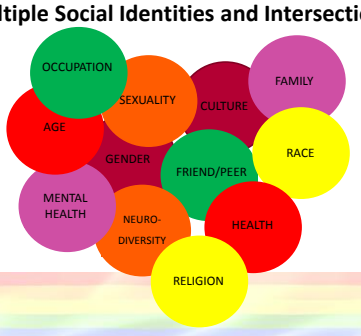
Asking about name and pronouns

- Ask what pronouns the young person prefers (both privately and publicly)
  - What pronouns would you prefer me to use with you?
  - And how about other staff, such as reception staff, other agencies, parents?
  - How about when I leave messages for you on your phone or with others?"
- Ask about preferred name
  - "You have recorded your name as X, is this your preferred name or do you prefer to be called a different name?"
  - If relevant during treatment explain that on some official reports their birth name can only be changed if legally done so

Evidence-based core principles

- Provide care that affirms the young persons' identities
- Be a knowledgeable and informed clinician– consult when needed
- Assess, refer, and collaborate if medical interventions are clinically indicated to reduce the distress of gender dysphoria
- Support an individual on their journey – don't impose a narrative and/or end point
- Be prepared to support and advocate for the young person within their families and communities

Multiple Social Identities and Intersectionality



Transgender Emergence – A Developmental Model (Lev 2006)

Stage 1: Awareness

- Individual may present in distress
- Task: normalise the experiences involved in emerging gender identity

Stage 2: Seeking information/Reaching out

- Seeking to gain education and support
- Task: Facilitate linkages and encourage outreach

Stage 3: Disclosure to significant others

- Task: Supporting integration to systems and ensuring safety

Stage 4: Exploration – Identity and self-labelling

- Task: Support the articulation and comfort with one's gendered identity.

Transgender Emergence – A Developmental Model (Lev 2006)

Stage 5: Exploration - Transition issues/possible body modification

- Exploration of options for transition regarding identity, presentation, and body modification
- Task: Resolution of the decisions (add: assessment), and advocacy

Stage 6: Integration- Acceptance and post-transition issues

- Consolidate and integrate gender identity
- Task: Support in adaptation to transition related issues

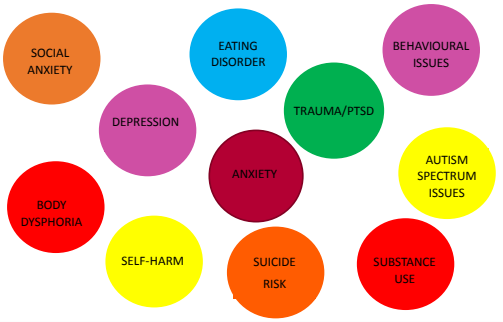
Therapeutic challenges

- Internalised transphobia
  - Labelling and exploring beliefs about self
  - Work towards self-acceptance. Therapeutic relationship can be powerful
  - Belongingness
- Families of faith, clash of religion and identity
- Colluding with helplessness
  - Ongoing supervision and self-reflection
- How to work with the individual in the therapy room, when the issue is with the politico-cultural context
- Be mindful of use of body based meditations/exercises
- Integration of self vs the desire to go "stealth"

Social anxiety

- Predisposed by often very high rates of bullying and rejection during childhood and adolescence
- Current experiences of the world/others as unsafe, critical, rejecting, persecutory
- Not usually a misinterpretation/misperception of reality
- Overly preoccupied with perceptions from others, especially whether people are looking at them
- Ultimate therapeutic goal of "caring less" about what others think, while also managing safety/rejection issues

Common comorbid presenting issues



Family Responses

- 65.8% report lack of family support
- What constitutes rejection? Subtle vs. overt
- Family acceptance important for self-acceptance of identity
- Acceptance has a range of positive impacts
  - Greater self-esteem and self-acceptance
  - Lower rates of depression and suicidality
- Rejection – significant negative impact (vs. none or low rejection)
  - 8.4x attempted suicide
  - 5.9x high levels of depression
  - 3.4x use of illicit drugs

How to respectfully describe clients in notes and formulation

"Max is a 16-year-old affirmed male, assigned female at birth who identifies at heterosexual. He presents with…."

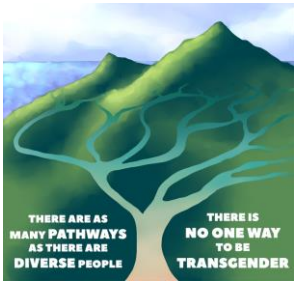
"Jess is a 20-year-old pansexual transwoman of Aboriginal descent"

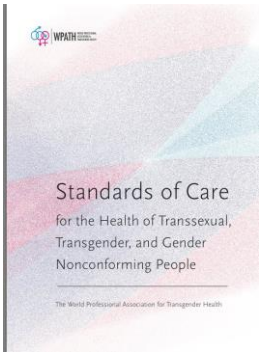
"Rin is a 18-year-old natally assigned female who identifies as gender non-binary and same-gender attracted. They present with…"

"Ben is a 17-year-old cisgender gay male who presents with…"

"Kate is a 23-year-old cisgender heterosexual Burmese female presenting with…"

Gender Affirmation





World Professional Association for Transgender Health SOC7

Free download through www.wpath.org

WPATH: Standards of Care Version 7 (SOC7)

- WPATH is an international, multidisciplinary, professional association founded in 1979.
- SOC aim to provide clinical *guidance* for health professionals to assist transgender and GNC people with safe and effective pathways to achieve lasting personal comfort with their gendered selves in order to maximise health and overall psychological wellbeing.
- Informed consent and harm reduction model.

Gender Affirming Treatment: Transitioning

Fully reversible interventions	• Social transition: changes in gender expression (e.g. pronouns, name use, gender marker, clothing, breast binding/padding) • IPL • Voice and communication therapy • GnRH analogues, androgen blockers
Partially Reversible interventions	Masculinising and feminising hormone therapy
Irreversible interventions	Gender affirming surgical procedures

Social transition

- Process of "coming out" to self, others, and making changes to live as their affirmed gender
- Can be empowering for clients to begin this process while waiting for access to medical transition
  - Important process to ensure readiness for hormones
  - Some complexities in clients with autism
- Public event- very confronting
- Important to have "lived experience" in exploration of self, even if just in safety of own room or therapy office

Legal documents

- Change of gender: Passport
  - Medical practitioner or psychologist to provide support on application
- Change of gender: Medicare
  - Done in person at local service centre
  - Statement from medical practitioner or psychologist or Passport that specifies gender
- Change of name
  - $165
- Change of birth certificate
  - http://www.courts. dotag.wa.gov.au/g/ gender_reassignment_ board.aspx#downloads

Medical Interventions for Gender Diverse People

- Not all gender diverse people will want medical treatment to affirm their identity
- Do not assume – must ask, and respect their choice
- A number of people will want medical treatment (ie. hormone treatment and possibly surgery), and will request this with urgency due to their distress
- The aims of medical treatment are to assist in affirming the individual's identity, reduce body dysphoria, and improve psychological and social well-being

Rationale for medical treatment under 18 years

- Changes associated with puberty are often associated with worsening of gender dysphoria and this can be relieved with puberty suppression
- Gender dysphoria rarely desists after the onset of pubertal development
- Pubertal suppression is effective, reversible and safe. Puberty is an irreversible process- doing nothing is not neutral
- Research has demonstrated that medical intervention at the optimal time leads to better physical and psychological outcomes with decreased need for surgical interventions in the longer term (e.g., mastectomy)

Medical treatment for under 18s

1. Assessment by an Endocrinologist, Psychiatrist, and Psychologist to confirm gender issues and readiness/willingness for medical treatment. **Fertility considerations**
2. Engagement in psychological counselling throughout the process
3. Once puberty begins, initial hormone treatment to suppress pubertal development
4. Introduction of "cross-sex" hormones at the age of 16 years .This step requires Family Court approval
5. Surgery is usually not recommended under the age of 18 years, some exceptions for chest surgery

Multiple barriers for under 18yo young people in this process, and commonly high levels of distress

Medical treatment for over 18s

- Family Court approval not required
- WPATH guidelines recommend (but not require) an assessment by an experienced Endocrinologist/doctor and mental health clinician
- Criteria for hormone treatment are:
  1. Persistent, well documented gender dysphoria
  2. Capacity to make a fully informed decision and consent for treatment
  3. If significant medical and/or mental health issues are present they must be *reasonably* controlled

Feminising hormone treatment

- Anti-androgens to suppress testosterone
- Oestrogen then commenced

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

Effect	Expected Onset[B]	Expected Maximum Effect[C]
Body fat redistribution	3-6 months	2-5 years
Decreased muscle mass/ strength	3-6 months	1-2 years[C]
Softening of skin/decreased oiliness	3-6 months	unknown
Decreased libido	1-3 months	1-2 years
Decreased spontaneous erections	1-3 months	3-6 months
Male sexual dysfunction	variable	variable
Breast growth	3-6 months	2-3 years
Decreased testicular volume	3-6 months	2-3 years
Decreased sperm production	variable	variable
Thinning and slowed growth of body and facial hair	6-12 months	> 3 years[D]
Male pattern baldness	No regrowth, loss stops 1-3 months	1-2 years

Feminising medical treatment options

- Impact of oestrogen on emotions
- Gender non-binary hormone options- often just want anti-androgens
- Gender-affirming surgeries
  - Vaginoplasty (construction of vagina)
  - Penectomy (removal of penis)
  - Orchidectomy (removal of testes)
  - Clitoroplasty (construction of clitoris)
- Facial feminising surgery (eg. tracheal shave)
- Breast augmentation
- Laser hair removal

Masculinising hormone treatment

- Puberty blockers (only for under-18s)
- Testosterone (usually injections)

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [a]

Effect	Expected Onset[b]	Expected Maximum Effect[b]
Skin oiliness/acne	1-6 months	1-2 years
Facial/body hair growth	3-6 months	3-5 years
Scalp hair loss	>12 months[c]	variable
Increased muscle mass/strength	6-12 months	2-5 years[d]
Body fat redistribution	3-6 months	2-5 years
Cessation of menses	2-6 months	n/a
Clitoral enlargement	3-6 months	1-2 years
Vaginal atrophy	3-6 months	1-2 years
Deepened voice	3-12 months	1-2 years

[a] Adapted with permission from Hembree et al (2009). *Copyright 2009, The Endocrine Society.*
[b] Estimates represent published and unpublished clinical observations.
[c] Highly dependent on age and inheritance; may be minimal.
[d] Significantly dependent on amount of exercise.

Masculinising hormone treatment

- Impact of hormones on sex drive and anger
- Chest (or "top") surgery eg. bilateral mastectomy
- Hysterectomy and oophorectomy (removal of uterus and ovaries)
- Nongenitial, nonbreast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants
- Genital reconstruction
  - Phalloplasty (construction of penis- poorly developed so far, and very expensive)

Mental health assessments for medical interventions

- Assess decision making capacity – informed consent
- Assess gender dysphoria in the context of an evaluation of psychosocial adjustment
  - Exploration of gender identity and gender dysphoria
  - History and development of gender dysphoric feelings
  - Impact of stigma on MH, availability of social support
- Provide information regarding options for gender identity and expression, including possible medical interventions
  - Psychoeducation
  - Referral to a relevant medical providers
  - Implications of any psychosocial impacts of change in gender role/expression and medical interventions
  - Explore expectations of interventions

Mental health assessments for medical interventions

- Assess, diagnose, and provide treatment for coexisting mental health concerns
  - Untreated MH issues complicate exploration of gender identity
  - Impede capacity to provide informed consent
  - Assess need for psychiatry involvement
- If applicable, assess eligibility, prepare, and refer for medical treatments
  - WPATH SOC provides criteria to guide decisions related to readiness for medical interventions
  - Support exploration of realistic expectations
  - Practical considerations (e.g. contraindicative medical issues)
- Provide continuity of care
  - Monitoring impact on mood/mental health concerns
  - Provide support navigating process – medical and psychosocial

Systemic

- Client-led
- Advocacy
- Privacy
- School uniform
- Bathrooms
- Change rooms
- Sports
- Name roll
- School camps
- School policy

A take home message….

It's a journey, not an end point– reduce pressure on yourself to know. Gender and sexuality are complex, fluid, and evolving.

Resources

Safe Schools

www.safeschoolscoalition.org.au

Referral and Consultative Services

- Living Proud (previously Gay and Lesbian Community Services - GLCS)
- The Freedom Centre (up to 26 years)
- The WA AIDS Council (WAAC)
- YouthLink
- Gender Diversity Service (GDS - PMH)
- RPH Sexual Health Clinic
- SCGH Endocrinology
- Parents and Friends of Lesbians and Gays (PFLAG)
- Mental Health Professionals Network
- Australian and New Zealand Professional Association for Transgender Health

Websites

- www.openingclosets.com
  - Facts, policies, resources and referral options for service providers.
- www.freedom.org.au
  - Information, resources, links, and support for young LGBTI people. Includes information about their drop-in space.
- www.acon.com.au
  - A leader in LGBTI health and wellbeing, based in NSW but providing an online support service.
- www.qlife.org.au
  - National counselling and referral service for LGBTI people. Phone and online counselling available 5.30pm – 10.30pm, ph: 1800 184 527.
- www.free2be.org.au
- www.lgbtihealth.org.au
  - National LGBTI Health Alliance page. Current mental health resources including LGBTI Champions project

Websites

- www.pflagaustralia.org.au
- www.transgendercare.com
- www.trans-health.com
- www.ausgender.com/
- www.equalityrules.info
- www.glhv.org.au
- http://au.reachout.com/Wellbeing/Personal-Identity/Gender
- www.ftmaustralia.org
- www.t-vox.org
- www.tsroadmap.com
- www.gendercentre.org.au
- www.atsaq.com/new-g-clinic.html

Supports/Referrals - GPs

Dr Elizabeth Kerr	(08) 9486 4556
Dr Mark Kent	(08) 9486 4556
Dr Fiona Campbell	(08) 9285 5100
Dr Helen Wilcox	(08) 9381 8154
Dr Maria Kailis	(08) 9387 2000
Dr Rowena Koek	(08) 9381 8154
Dr Kathi Bleeker-Suazier	(08) 93075344
Dr Fiona Coombes (Curtin only)	(08) 9266 7345
Dr P Helmuth	(08) 9446 6979
Dr Juliet Tan	(08) 9306 1940
Dr Ashford	(08) 9434 3555
Dr Nicola Woods	(08) 9439 4411
Dr Jenny Ho	(08) 9225 1188
Onslow Road Family Practice	(08) 9381 4733
GP on Beaufort (Dr Wozencroft, Dr McCabe)	(08) 9262 8600
Dr Glynn Hughes	(08) 9272 2455

Referrals - Psychiatrists

Dr Geetha Menon	(08) 9494 3723
Dr Russell Date	(08) 9488 2983
Dr Rebecca Rhys-Maitland (children)	(08) 9486 5800
Dr Frederick Ng - (13yr and under)	(08) 9486 7255
Dr Helena Piirto	(08) 9385 0077
Dr. Jarek Komeda-Hryniewi	(08) 9486 7399
Dr. Charmaine Myers	0411 898 122
Dr Jane Fitch	(08) 9339 8088
Dr Emma Briggs	(08) 9389 2300